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ABSTRACT

This paper describes the development of clinical programs for the psychiatric needs of refugees. It begins with a discussion of the known psychiatric epidemiology of immigrants and refugees: the increased likelihood of depression, schizophrenia, reactive psychoses from trauma, and organic or psychophysiological disorders. Barriers that refugees experience in receiving services are next discussed, along with the basic issues that clinical programs must address to meet refugee needs. The staffing needed for an effective program is considered, including the psychiatrist, the bilingual mental health workers, and other therapists, while program content should include cross-culturally valid psychiatric assessment, regular program evaluation, and medical evaluation of refugees. After a hypothetical discussion of the ideal program and the barriers to achievement of such an ideal, the psychiatric program for Southeast Asian refugees at the Oregon Health Sciences University is described to illustrate various approaches to providing refugee mental health services. Other clinical services in other settings are briefly reviewed, and the paper concludes with a discussion of training needs for counselors and bilingual staff. References are included. (TE)

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Psychiatric Clinical Programs for Refugees: Development, Staffing, Structure, and Training

by

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The goal of this paper is to describe the development of clinical programs for the psychiatric needs of refugees. We will describe the known psychiatric epidemiology of immigrants and refugees: barriers that refugees experience in receiving services; the basic issues that programs must address to meet those needs, and the staff and program content needed for an effective program. We will suggest how such programs may be practically implemented in various settings: medical centers, psychiatric hospitals, and mental health clinics. The author will describe experiences at The Oregon Health Sciences University, where a psychiatric program for Southeast Asian refugees has been in place for nine years, to illustrate the various approaches to providing these services.

A. Psychiatric Epidemiology Studies Among Emigrants and Refugees

Several recent good reviews of the literature of psychiatric disturbance among immigrants and refugees have brought together a large body of information.[1,2,3] These have demonstrated conclusively that new immigrants to a country are at a high risk for psychiatric disorders. These findings, for at least 50 years, are stable and real, whether the data comes from epidemiological studies, hospital admission rates, or clinical case studies.

Depression is found to be greatly increased among refugees and is the most frequent problem mentioned in those seeking treatment. If undiagnosed and not treated, depression can be quite severely impairing. Schizophrenia has an increased incidence in refugee populations, although only a small percentage are affected. However, because of the extensive disability, prolonged course, and periodic hospitalization, it requires many resources to treat. Reactive psychoses following a definable stress are also increased among refugees. These may take a paranoid nature. Many refugees have been exposed to head trauma, malnutrition, or other insults which can affect the brain. There may be a resulting organic brain syndrome of mental retardation. Despite the lack of clear studies on

this, these conditions are encountered frequently in clinical practice.

Somatization and psychophysiological disorders, although they may not actually be higher among refugees, are commonly seen initially as the presenting medical problem of many refugee patients. These can lead to unnecessary hospital admissions and delay the appropriate psychiatric treatment. Refugees who have had massive trauma due to persecution, war experiences, or concentration camps suffer from the post- traumatic stress disorder which can have a chronic and debilitating course.[3]

Clearly programs designed for refugees must be prepared to handle many patients with depressive symptoms, those patients with a chronic course of schizophrenia, those with mental retardation or organic brain syndromes, and an increased incidence of post-traumatic stress disorder. The patients also may somaticize a great deal which would make early diagnosis of some of their psychiatric disturbances difficult. Clinical experience has indicated that as patients become more Americanized they have more disorders that are found in the United States such as alcohol and drug abuse, family violence, child abuse, and perhaps antisocial disorders.

B. The Refugee Patients

Refugees differ from immigrants in that they have been forced to leave their homelands and usually have not the choice to return. Often their leaving was abrupt and chaotic without the time to learn the language of the host country. Furthermore, they bring with them the beliefs, values, and culture of their homeland. These may impede them in obtaining services for their psychiatric disorders. Asian cultures have often stigmatized those who have had severe mental illness. It was such a fearsome thing that families often concealed an impaired family member from outsiders. For many forms of distress, Asians do not separate physical and mental disorder. Many difficulties are expressed in somatic symptoms such as headache,

backache, poor sleep, which then need to be addressed medically rather that seeing a mental health professional. Furthermore, Asians' own conceptualization of disorders often involve tradition, such as the Chinese Yin-Yang theory, or supernatural belief systems. The refugee's previous contact with Western doctors may have involved surgical procedures or treatment of infectious diseases where rapid treatment was possible. The refugees may not understand the need for long-term treatment nor the need for personal self- revelation which are involved in psychiatric disorders. Furthermore, the number of Western specialists treating medical diseases (i.e., general practitioners, internists, psychiatrists, nurses, psychologists, social workers, etc.) may be a source of confusion.

American health care providers often have little experience with Asians and not sensitive to the needs of the patients. Often inadequate language interpretation or knowledge of their culture prevents appropriate diagnosis.

The American and Asian value systems may provide important barriers to treatment. American's values of autonomy, independence, future-looking, progress-minded can counter the interdependence, family-oriented, past-directed, and value of living in harmony with one's surroundings of many Asians.[4] Because of these differences which have also been found in American-Asian patients, there is a great tendency to under- utilize mental health services[5] or not to comply in the treatment.[6]

C. Clinical Programs: Basic Issues and Approaches

To meet the needs of the refugee population and to appropriately address the refugee's difficulty in getting adequate psychiatric treatment, several issues need to be addressed in a developing program.

1. The program needs to address the major psychiatric disorders in the refugee populations in an appropriate clinical setting. From studies of the disorders common in refugees, it is clear that their most disturbing disorders are psychoses, such as schizophrenia, brief-reacting psychosis, and severe depression. Treating these disorders should be the first priority of the program because they cause the most disability and tend to be the most disruptive to both refugees and health care providers. This means that emergency rooms and inpatient settings are needed for acute phases of the disorders and that programs need outpatient facilities and medication for the chronic phases. Moderate to severe depression is the most common of all psychotic disorders among refugees. Somatic presentation may make a diagnosis difficult. Patients may need medicine and individual or family education and therapy. The issues of depression are very closely linked with issues of adjustment to the new country. Post- traumatic stress disorders for those victims who have been tortured or undergone chronic persecution and trauma need to be addressed. These are severe disorders often with chronic impairment and whose presentations may not be known for years. Neurological disorders such as organic brain syndromes and mental retardation as a result of previous trauma, infection, or brain injury are very difficult to diagnose, but the ability to do so is essential for a program.

2. The program must address the language needs of the refugees. That means having well-trained interpreters who can speak both their own language and English, can translate between them, and are familiar with terms and concepts used in mental health.

3. The program must address special cultural issues of the patients. This means the expectations for treatment, causation of the disorder, the family's involvement, and the stigma must be sensitively dealt with within the program. The therapist need to be active, flexible, non-threatening, and able to reduce symptoms as quickly as possible, much as Western doctors do. There is need for

the program to recognize what therapies are culturally appropriate for refugee patients.

4. The program needs to identify and diagnose both physical and mental problems. Obviously, refugees represent a population of people who have multiple medical problems as well as psychiatric problems. They, and indeed many physicians, cannot always separate them, and both can co-exist. It is important that a program have the ability to make diagnosis of both disorders.

5. There must be easy access to the program. Often problems in the refugee communities are not anticipated. There are crises which need to be met quickly or the opportunities for both patient and physician are lost. There is a need for early appointments without a long waiting list or a complicated screening procedure. It is important for counselors with the appropriate language skills to return calls, give adequate information, and make sure that patient's needs are met rapidly.

6. The program must establish credibility within the entire refugee population. That is, it must appear to be competent and successfully treat the patients. It must meet their needs in an appropriate manner which is identified by the patients as being helpful, and it must be willing to make a long-term commitment with their community to take care of psychiatric disorders. This means brief programs or those offering time-limited therapies of limited nature will often be seen as unreliable and unstable.

7. There needs to be clear linkage with continuity of all services. This means inpatient, outpatient, day treatment, crisis intervention, appropriate social agencies, and other helpers must have clear communication and be united in providing care.

8. The program needs to have a mechanism, preferably formal, for the refugee-patients to give feedback on the program and advice on future directions. The patients then can participate in exerting

appropriate input and suggestions in the program and have become partners in its development. One method is the establishment of a patient advisory group in which patients from different refugee ethnic groups meet regularly with the clinic staff to advocate for program development.

9. The rehabilitation of the psychiatric refugee will require therapy which helps the patient understand and cope with American life. In addition to the development of pro-social skills which are necessary for the treatment of chronic patient, the refugee patient needs to learn social behavior for American life. Therefore a program needs to help the chronic patients participate in American activities and interact with Americans. An active program of selected and trained volunteers can greatly help this interaction and give the refugee-patient a safe and informative manner of learning to live in American society. A formal series of educational sessions or such topics as shopping, riding the bus, renting, and applying for a job can also be very helpful.

D. Staffing

1. Psychiatrist

It is important that the psychiatrist involved in the psychiatric care of refugees be a broad-based, competent general psychiatrist with the ability to handle the wide variety of psychiatric disorders specifically found among refugees. It is necessary that he/she provide the necessary clinical skills to establish credibility with the patient populations. In addition, it is essential that he/she has some transcultural training and experience to deal with the cultural issues involved in the refugee experiences. He should understand diagnoses in a cross- cultural perspective and avoid problems of under- or over- diagnosing.[7] The personal qualities should include gentleness, subtlety, and maturity. The physician needs to fit the role of a

healer and one who can act in a crisis without increasing the anxiety of all concerned. Knowledge about the use of multiple medicines which the patients may need is essential. Ideally, the psychiatrist should be involved in the inpatient and outpatient treatment to help maintain the continuity of care of the patient. Although facility in the language of patients involved is very useful, it is impractical that the therapist would be able to understand all the languages spoken by refugees from Southeast Asia. When one is known fluently, it would facilitate communication and decrease the problems involved with the bilingual mental health workers.

2. The Bilingual Mental Health Workers

These are the people who can do the interpretation between mental health professionals and the patients. They are called by different names such as mental health worker, counselor, health aides, etc. The are absolutely essential in a multi-lingual program. The problems and role of these workers has been addressed very well by Egli.[8] The problems for these cross-cultural mental health workers are many. Usually they have had no mental health or psychiatric training, therefore they are unfamiliar with mental disorders and their treatment. They often have the same biases as the patients, that is fear and ridicule of mental illness. Often, too, they have gone through the same experiences as the patients, sometimes the same traumas and persecution and have many unresolved conflicts and disorders. Often their work is seen as having low status among the refugee community. Furthermore, they often have very limited English skills and are unprepared to deal with subtleties of communication needed in therapy. They may be sensitive or defensive about their own culture and values, or alternatively protective and defensive about the techniques of psychiatrists who at times can be abrupt and direct. For bilingual mental health workers to be effective, several qualities are needed:

a. Their English skills need to be good.

b. They must be able to interpret correctly and appropriately, clearly interpreting words of both patient and physician as well as the appropriate affect.

c. At times they must be able to provide the cultural brokerage to translate and interpret the respective cultures of the parties involved.

d. They must have the skills of a case manager, that is, to be able to care for chronic psychiatric cases and as well as to help the refugees' adjustment to their new country.

e. They need to learn some beginning counseling techniques to become appropriate therapists for the patients.

f. They need to have the personal qualities which enable them to fulfill their role. These include warmth, empathy, genuineness, and openness.

3. Other Therapists

Nurses, social workers, psychologists, and volunteers may all be involved in the program. The nurse's role is often clearer since most cultures are aware of Western nurses: They serve in health maintenance, the giving and explaining of medicine, and in the actual providing of much medical services. Other therapists' roles are less clear since they involve the relationship and psychological interactions which may not be clear to the patients. They need to be flexible, open, active, and supportive in their interactions with patients. They need to be on guard against excessive psychologicalizing of the difficulties of refugees, especially early in the relationship. It is important that such therapists become continually involved in the evaluation of patients since emergencies or change in clinical condition can frequently occur. It is important

also that all involved in the therapeutic care of patients experiment with caution to new approaches in families, groups , socialization, education, and even friendship. Often interpreters or the bilingual mental health counselors will need to help these therapists as well.

4. Evaluations

The assessments of psychiatric patients cross-culturally is a very difficult task, as stated by Westermeyer[7]. It requires a great deal of sensitivity and skill. In addition to the interviews, self-rating scales can be used. The Vietnamese Depression Scale[9] is an example of one which has been used with the Vietnamese. Psychological testing cross culturally creates problems in terms of validation and the lack of standardizations. It is difficult to develop a culture-and-education-free scale. Westermeyer has had experience in using some scales cross-culturally.[7] In addition to individual's evaluations, a program needs to assess its own ability to provide appropriate services. This means continual evaluation of whether or not a program is meeting the psychiatric needs of a refugee population as these needs change over time. These would necessitate developing strategies and techniques to evaluate the program. A further component of this is to develop formal research in the clinical services for refugees.

5. The Medical Evaluation

The medical evaluation needs to be readily available to the refugee patients. Psychiatrists with this medical training can aid in this. It is important that the program have physical exam rooms, laboratory testing, and referral to specialists.

E. The Ideal Program

The program which included all of the previous components would indeed be an ideal program and not be entirely possible. It would have transculturally trained psychiatrists familiar with the culture who are medically competent and can speak some of the languages of the patients. They would be warm, sensitive, patient, and able to treat the refugees both in the inpatient and outpatient settings; make appropriate medical diagnoses, and be competent in pharmacotherapy, social therapies, culturally appropriate individual psychotherapies. There is the need for bilingual staff who would be warm, sympathetic, and able to be interpreters, counselors, case managers, and who would help the refugees feel respected, comfortable, and well-liked by the staff. The referrals within the system would made easily, such as the ability to respond quickly to an emergency, to hospitalize rapidly, and to discharge to ongoing care either outpatient or day treatment. There should be no waiting list and no barriers to treatment. Obviously, they should be able to handle severely disruptive psychotic patients as well as those with milder psychiatric disorders. There would be an active advisory group and composed of patients, who could give feedback on and advocate for the program. A group of volunteers working with the patients could greatly increase the interaction with Americans and help with adjustment and acculturization to American life. There should be a clear program evaluation procedure which would have research potential, i.e., the evaluation would identify problems in service delivery and help modify the approaches.

The reasons that an ideal program for refugees cannot be done are probably similar to all those programs in public psychiatry in the United States. Understaffing and underfunding are some of the basic issues which would certainly affect all of those providing services to refugees. One of the biggest problems is the discontinuity of care. Inpatient, outpatient, and emergency room facilities are often only tangentially related to each other if at all. Often the staff is poorly trained and many centers rely partly upon paraprofessionals. There is much difficulty in individualizing a treatment program for either

inpatient or outpatient areas. Since all public psychiatry programs have these problems, it is no wonder that specialized programs for refugees are so difficult to run. There is really little knowledge available of the cultures they serve in many psychiatric centers. Often there is an unnatural separation of physical and mental health facilities, little understanding of the refugees' experiences and language, and few or no other refugees or Asians involved in the care and the treatment in these centers. Therefore the refugees feel very much alone and unappreciated.

F. Development of the OHSU Indochinese Psychiatric Program

In 1978, the University of Oregon Psychiatric Deparment began an Indochinese clinic. It was begun with one psychiatrist who had previous experience in transcultural psychiatry with Asians and a Vietnamese physician who was a resident in psychiatry. An associated program to train mental health counselors in Vietnamese, Laos, Cambodian, Mung, and Mein cultures joined with the department to provide the bilingual component to the program. The program emphasized a medical approach where the psychiatrists were able to present themselves as physicians to the patients, offer a thorough evaluation, symptomatic relief, and supportive therapy. The program was designed to take the most severely impaired patients, i.e., psychosis and severly depressed patients, as rapidly as possible. There was no waiting list. Patients were seen originally within a week of referral. All patients referred were accepted with minimum of screening. Referrals came from physicians, public health nurses, and social welfare agencies. Many patients were acutely ill and had to be hospitalized after disruptive behavior. There was an attempt to establish competence and relationship with communities and with the refugee communities involved. And private meetings with agencies and community leaders helped to establish competence and further backing from the organizations involved.[10,11,12]

The program greatly expanded over the subsequent ten years. The number of psychiatrists interested in the area increased to currently the program has five on a part-time basis. A nurse provides medical backup for the physicians and helps to assist in all referrals. A social worker is involved in administrating parts of the program and in training the new counselors. The bilingual staff have advanced to become counselors who have their individual case load involving counseling and case management. Treatments have greatly expanded to include socialization[13] groups involving the great majority of patients as well as the individual therapy and pharmacotherapy.[14] Currently the active patient load is over 320 and the program has evaluated over 650 patients during this time. Of the patients, over 20 percent have been hospitalized had 20 percent are chronically mentally ill. These decreased somewhat from the earlier days when a higher percentage were psychotic. PTSD has become a major focus of the treatment program and currently drug abuse and violence have also become an identified problem. It has become necessary to have access to many other physicians as the clinic has become in some sense a primary care of the disorders. Blood pressures as well as medicines are monitored frequently and some medical disorders are treated in the clinic itself. One staff member has the responsibilities of coordinating the volunteer program. Over 10 active and interested, and fairly sophisticated American (so far all Caucasians) volunteers are involved in various aspects of the program. Often they will participate in the socialization group activities, provide some special progams to patients, and continue to have informal and purely social visits with the patients. Inviting the patients to their homes have been a very well received activity. A patient advisory group has been started. Patients representatives from Vietnamese, Camodians, Loa and Mein groups meet with a staff worker regularly to discuss the program and future planning. Several long field trips (one to Vancouver, B.C.) were initiated by the group. Although language differences and sometimes ethnic prejudices decrease the groups effectiveness, it is the beginning of the patient's becomming more active participants in their own programs.

The major shift in the clinic has been to obtain its own funding. When an affiliated program for mental health counselors could no longer obtain funding, the Department of Psychiatry became the primary center for Indochinese services. It was funded with much help from the State Mental Health Division and the local county mental health authorities. The budget now comes half from the State Mental Health Divison and one-half must be received from patient fees, usually through Title XIX or Welfare sponsorship. Our program continues to function as a research center in addition to its clear designation as a mental health center. As it is associated with a general hospital, patients can be easily seen in the emergency room, be admitted to the wards with the same attending physicians, and can have easy referral to other specialists. The lack of a day-case program or residential treatment has clearly limited the progams effectiveness in treating the chronically or socially isolated mentally ill patient.

G. Other Clinical Services in Other Settings

Without a full medical center, many programs for refugees need to be in settings which generally have worked with American psychiatric patients. Often these settings are without the full compliment of services but do provide a great amount of care for the pscyhiatric refugee patient. To be successful, these programs need a core professional and administrative staff which actively supports refugees' mental health programs. They also need a core group of ethnic bilingual counselors or mental health workers to aid in the translation and support the refugee patients. They need to attract a critical mass of refugees, i.e., enough refugee patients so that individual patients do not feel alone, have the others to speak the same language, have the same culture, and the same appearance. This also facilitates interactions and support. The programs need to have success and be perceived as by the refugee community as being competent and credible. The patients must feel understood, helped with reduced symptoms, and family needs met. Many programs which

have these attributes have been well described by Jaranson and Bamford.[15]

Several state hospitals or psychiatric wards in general hospitals have established separate wards for Asians or refugee patients.[18] These are often directed by an Asian himself who has the language and competence to treat these patients. Often a specially trained staff, including many Asians, are recruited for these services. Many of these services are run much like a psychiatric ward would be in Asia with a full range of services including individual and group therapy often with a very dedicated and competent staff. In many ways there are facilities where the language and the culture of the patient are recognized and the same programs for American patients are valued. The primary difficulty that some of these programs have experienced is in following and providing continuity of care to their patients. Since in many public setting inpatient and outpatient facilities are handled by a different staff, sometimes with little communication.

There are several clinics which have been established for Indochinese or other Asian groups.[17] These are specialized clinics which are staffed by Asians and provide a variety of therapeutic services. Usually these tend to have a psychotherapeutic orientation with less medical influence. They provide multiple services such as counseling and rehabilitation. A consulting psychiatrist often issues a diagnosis and medication. Some difficulties that these clinics have encountered is handling acute or psychiatric emergencies, getting patients admitted to hospital, and providing ongoing contact when they are in the hospital. A wide range of services however are available to these patients.

Perhaps most Asian refugee patients are treated in community mental health clinics where the primary goal has been to treat American psychiatric patients, increasingly the chronic patients. These clinics have attempted to treat Indochinese patients or other Asian patients referred to them and a few have even attempted to attract refugee patients as a stated goal. Such clinic have needed to recruit a core group of staff who was interested in and gave priority to the Indochinese patients. Often there were competing financial and staffing issues which put the refugee patients in the lower priority compared to other patients. These clinics vary, some emphasizing rehabilitation service to chronic metally ill; others emphasized more psychotherapeutic orientation. Asian patients may feel out of place of frightened by the American psychiatric patients. By their very very nature, these clinic require patients to admit that they have a psychiatric problem - a difficult thing for many Asians to do. Because of the other interests and pressures of the clinic, it is often difficult to maintain the skills, language, and cultural sensitivity needed to provide all the necessary help for the Asian refugee patients.

H. Training

Training has become a major function of all psychiatric programs for refugees.[18] Training is a two-way process and involves the American staff in the ways, culture, disorders, problems of the refugee patients and involves the bilingual staff in training about psychiatric and psychological disturbances and therapeutic techniques. The staff itself needs to constantly evlauate and train themselves for the evolving processes among refugee, not only among the psychiatric disorders but the adjustment problems and the changes in these problems over time in a new country. This not only involves mutual learning, the sharing of cases, evaluation of the program, and contact with other programs. Ongoing relationships

with community is particularly important to meet their needs in providing services.

Training for the counselors and bilingual staff is particularly important. Our program has been involved in training since its inception. It is has been particularly necessary since the staff is becoming more and more the mainstay of the clinic. We have very fortunate that the first staff hired were mature and sensitive individuals who commanded much personal respect within their respective communities. All had American university training. Nevertheless, it took a great deal of education and clinical experience to develop the skills to the point where they could manage successfully the dual role of counseling and interpretation involved with psychiatric patients. Since there is not a readily good source of such individuals, it is necessary for a program to train their own to get the skill levels to an appropriate level. In our experience it takes at least two years of clinical service and training to have a person operate appropriately as a mental health counselor. The training program that we have offered involves individual observation and discussion about interactions with patients and the necessary cognitive information about psychiatric disorders and their treatment.

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